Complete Summary

GUIDELINE TITLE

Identification of common mental disorders and management of depression in primary care.

BIBLIOGRAPHIC SOURCE(S)

New Zealand Guidelines Group. Identification of common mental disorders and management of depression in primary care. Wellington (NZ): New Zealand Guidelines Group; 2008 Jul. 188 p. [580 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Depression, including:

- Major depression
- Dysthymia
- Postnatal depression

Note: It is beyond the scope of this guideline to address the management of dementia.

GUIDELINE CATEGORY

Diagnosis
Management
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To provide a summary of current New Zealand and overseas evidence about the identification of common mental disorders and the management of depression among young people and adults in the primary care setting
- To identify evidence-based practice for most people, in most circumstances, thus forming the basis for decision-making by the health care practitioner in discussion with the person in developing an individualised care plan
- To promote clinical practice that will protect and improve Māori mental health as part of New Zealand's commitment to the Treaty of Waitangi

TARGET POPULATION

General population of New Zealand

Note: Among young people the focus is largely on adolescents as they are the most vulnerable.

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis and Screening

Young People

1. Applying strengths-based and biomedical models (enhancing resiliency, minimizing obstacles, social connectedness)
2. Screening
3. Psychosocial assessment
    - HEEADSSS (Home, Education, Employment, Eating, Activities, Drugs, Sexuality, Suicide, Safety)
    - HEARTS (Home, Education, Activities, Relationships, Temper, Size)
    - Biopsychosociocultural model of assessment
4. Additional assessment tools
    - Strengths and Difficulties Questionnaire (SDQ)
    - Short Moods and Feelings Questionnaire (SMFQ)
    - Reynolds Adolescent Depression Scale (RADS)
    - Substance Use and Choices Scale (SACS)
    - CRAFFT (Car, Relax, Alone, Forget, Family/Friends, Trouble) Tool
5. Clinical features
6. Diagnosis and referral

Adults

1. Psychosocial assessment
2. Targeted screening of high-risk groups using verbal 2-3 questioning screening tool
3. Additional assessment tools
    - Patient Health Questionnaire for Depression (PHQ-9)
    - Kessler Psychological Distress Scale (K10)
    - Generalised Anxiety Disorder Assessment Tool (GAD-7)
    - Alcohol Use Disorders Identification Test (AUDIT)
    - Case Finding and Help Assessment Tool (CHAT)
4. Diagnosis and referral

Women (Antenatal and Postnatal)

1. Screening using verbal 2-3 questioning screening tool
2. Assessment tools
    - Edinburgh Postnatal Depression Scale [EPDS]
    - Patient Health Questionnaire for Depression [PHQ-9]
    - Hospital Anxiety Depression Scale [HADS])

Older Adults

1. Targeted screening of high-risk groups
2. Assessment tools:
    - Geriatric Depression Scale
    - Short Form (GDS-15)
    - Patient Health Questionnaire for Depression (PHQ-9)
    - Mini Mental State Examination (MMSE)

Management

Young People

1. Clinical management
    - Combined risk-management and strengths-based approach
    - Active support and monitoring
    - Self-management advice
2. Specific interventions
    - Guided self-help
    - Exercise
    - Psychological therapies (e.g., cognitive behavioral therapy [CBT])
    - Pharmacological therapies
    - Complementary and alternative medicines [CAMs])

Adults

1. Clinical management
    - Active support and monitoring
    - Self-management advice
2. Specific interventions
    - Guided self-help
    - Exercise
    - Psychological therapies (e.g., CBT, interpersonal psychotherapy [IPT])
    - Pharmacological therapies (e.g., selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs])
    - CAMs

Women (Antenatal and Postnatal Depression)

1. Clinical management
    - Patient preference and clinical experience
2. Specific interventions
    - Guided self-help
    - Exercise
    - Psychological therapies (e.g., CBT, IPT)
    - Pharmacological therapies
    - CAMs

Older Adults

1. Active support and liaison with other agencies
2. Specific interventions
    - Exercise
    - Psychological therapies (e.g., CBT, behavior therapies (BT), reminiscence and life-review therapies, IPT)
    - Pharmacological therapies (SSRIs)

General

1. Culturally specific models of care
2. Therapeutic alliances

MAJOR OUTCOMES CONSIDERED

- Quality of life
- Symptom severity, symptom persistence, and functional impairment
- Patient satisfaction
- Effectiveness of psychological therapies
- Side effects of pharmacological therapy
- Cost-effectiveness of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Clinical Questions

The Guideline Development Team (GDT) developed the following clinical questions:

1. What risk factors are associated with depression in children/adolescents/adults?
2. How do children/adolescents/adults with common mental disorders present in primary care?
3. Does routine screening for depression/common mental disorders/postnatal depression in children/adolescents/adults in primary care lead to improved outcomes?
4. What is the validity and utility of case-finding tools for assessment of depression, anxiety and dysthymia (either alone or with other common mental disorders) in children/adolescents/adults in primary care?
5. In children/adolescents/adults managed in primary care for depression do the following interventions improve outcomes:
    - A healthy lifestyle (e.g., complementary and alternative medicines, exercise, etc.)
    - Guided self-help
    - Psychological therapies
    - Pharmacological therapies
6. In children/adolescents/adults managed in primary care for depression, which models of liaison/teamwork/service delivery have the best outcomes (in general, and specifically for Māori and Pacific peoples)?

Evidence Collation and Appraisal

To address the clinical questions, New Zealand Guidelines Group (NZGG) used the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument to appraise the following international guidelines for the quality of their methodologies: Agency for Healthcare Research and Quality (AHRQ) 2002, National Institute for Health and Clinical Excellence (NICE) 2004, NICE 2005, NICE

2007. They were assessed as being well-developed and suitable for updating where they addressed one or more of the clinical questions.

The GDT determined that questions 3 to 5 required an updated search and systematic review, while questions 1, 2 and 6 could be answered with reference to the above-mentioned international guidelines, supplemented by a narrative review of New Zealand literature and literature published since the guidelines.

The research team determined inclusion criteria for studies pertaining to questions 3 to 6 and designed literature searches. The full searches and inclusion criteria for studies are available on the NZGG website (http://www.nzgg.org.nz).

Searches of electronic databases were undertaken and studies were retrieved.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

An overall summary level of evidence was assigned to each study, as follows:

(+) assigned when all or most of validity criteria met

(~) assigned when some of criteria met and where unmet criteria are not likely to affect the validity, magnitude/ precision or applicability of the results markedly

(x) assigned when few or none of the criteria met

Intermediate grades (+/~,~/x) were assigned when overall study quality fell between these categories. Studies that met few or none of the quality criteria were excluded.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Study Appraisal

Studies that met the inclusion criteria for each clinical question were appraised and graded for quality, using relevant checklists developed by the Scottish Intercollegiate Guidelines Network (SIGN). These were modified to incorporate summary levels of evidence for the validity, magnitude/precision of effect and

applicability of each study. An overall summary level of evidence was assigned to each study (see "Rating Scheme for the Strength of the Evidence" field above).

For every study included in the evidence review, the level of evidence assigned is listed alongside the citation in the reference list at the end of the guideline.

Weighing the Evidence

Evidence tables (which are available on the New Zealand Guidelines Group (NZGG) website (http://www.nzgg.org.nz) were prepared for each clinical question and were summarised on considered judgment forms The Guideline Development Team (GDT) considered the body of evidence and made recommendations, based on the validity, quantity, consistency and clinical impact of the whole body of evidence.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Guideline Development Team (GDT) developed consensus recommendations following a review and discussion of the evidence as expressed in the evidence tables and considered judgment forms. Recommendations are graded based on the level to which they are supported by the evidence.

Grading of the recommendations was based on the quality of the evidence, which does not equate to the importance of the recommendation. When there was no evidence to answer a specific question, recommendations were based on the consensus of the GDT and were classified as 'Good Practice Points'.

Two expert subgroups were convened to consider the evidence and draft recommendations for the specific populations of youth (children and adolescents) and older adults. The subgroups comprised both GDT members and external experts. Their recommendations were discussed and finalised by the full GDT.

New Zealand Guidelines Group (NZGG) drafted the guideline with support from Guideline Development Team (GDT) members, expert contributors and Māori perspectives from the NZGG Board of Directors.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grading of Recommendations

A - The recommendation is supported by good evidence (based on a number of studies that are valid, consistent, applicable and clinically relevant).

B - The recommendation is supported by fair evidence (based on studies that are valid, but there are some concerns about the volume, consistency, applicability

and clinical relevance of the evidence that may cause some uncertainty but are not likely to be overturned by other evidence).

C - The recommendation is supported by international expert opinion.

Good Practice Points (GPP) - Where no evidence is available, best practice recommendations are made based on the experience of the Guideline Development Team, or feedback from consultation within New Zealand.

COST ANALYSIS

The guideline developers reviewed published cost analyses:

- The literature strongly advocates the use of interdisciplinary team-based models of care as a cost-effective way of improving primary care outcomes for patients with depression.
- There is accumulating evidence that shared decision-making increases the cost-effectiveness of treatment, strengthens the therapeutic alliance and improves patient satisfaction.
- Cultural competence means that a practitioner has the attitude, skills and knowledge to work effectively and respectfully with people of other cultural backgrounds. The benefits include improved willingness to access services, improved communication, increased patient satisfaction and compliance with treatment, improved patient outcomes, and improved cost-effectiveness and efficiency in health service delivery.
- An Australian cost-benefit analysis of cognitive behavioural therapy (CBT) versus antidepressants found CBT the most cost-effective first-line intervention for depression in children and adolescents.
- Overall, the evidence suggests that psychological therapies and antidepressants are of comparable efficacy. Psychological therapies are better tolerated, and may have a more sustained effect, though the Guideline Development Team (GDT) notes that access to these therapies can be difficult due to barriers of cost and accessibility.
- Two randomised controlled trials (RCTs) evaluated the use of CBT booklets with practice nurse or assistant psychologist support. One found no benefit at 3 months in the intervention group compared to waiting list controls, while the other reported cost-effective clinical benefits to the intervention group compared with usual general practitioner (GP) care.
- An economic analysis calculated that non-directive counselling (home listening visits) were likely to be the most cost-effective option for treatment of women with mild to moderate depression in the postnatal period, but noted considerable uncertainty around this finding.
- Barriers to the adoption of collaborative care models could include financial or time costs to anyone involved, including patients and their families, and the need for substantial changes to clinical practice (e.g., protocols for follow-up or referral between services).
- An Australian study describes a modelling exercise that found that with the number of people needing treatment held constant, evidence-based care using a stepped care approach was no more expensive and was more effective than the traditional model (i.e., allocating resources top-down, according to the needs and demands of stakeholder groups). Increased coverage was also possible because the additional cases tended to be of

disorders that were easier and less expensive to treat. The model assumed a sequence of stepped care from the less intensive, lower-cost interventions (i.e., GP advice plus patient self-management), through to more intensive higher-cost interventions (i.e., active GP treatment, involvement of allied mental health staff and on to psychiatric and inpatient care).

- There is evidence that multifaceted collaborative care has benefits for the treatment of depression in the primary care setting. Potential elements of a cost-effective model include a stepped care approach, use of telephone care management and the employment of care managers (e.g., practice nurses) to work with patients and liaise across levels of care.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

- A draft of this guideline was circulated to 263 individuals and organisations for comment in December 2007 as part of the peer review process.
- The guideline was circulated nationally for feedback. Following consideration of the feedback, the guideline was redrafted. Significant changes were made to Chapter 7 of the original guideline document, following advice from a maternal mental health specialist, the New Zealand College of Midwives, the Royal New Zealand Plunket Society and general practitioners with an interest in this area.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of recommendation (A-C, and Good Practice Points [GPP]) are defined at the end of the "Major Recommendations" field.

Key Messages

- Mental disorders are common in primary care and are a major cause of disability
- All assessment, support and treatment of mental disorders in primary care should be culturally appropriate
- Routine psychosocial assessment is the key to improving the recognition of common mental disorders
- The use of verbal 2–3 question screening tools is recommended as a support for clinical assessment, when targeting adults at high risk for common mental disorders
- A high index of suspicion is needed for substance use disorder, which is common but often hard to recognise as it is relatively less disabling than other mental disorders
- Most young people and adults with depression can be managed within primary care using a 'stepped care' approach. A good outcome depends on

partnership between the patient and practitioner and on provision of active treatment and support for a sufficient length of time
- Planned treatment for depression should reflect the individual's values and preferences and the risks and benefits of different treatment options
- Use of self-management strategies for depression should be encouraged and supported by practitioners
- Psychological and pharmacological therapies are equally effective for treating adults with moderate depression, on the basis of current evidence
- Brief psychological interventions for depression such as structured problem-solving therapy should be available in the primary care setting
- Where antidepressant therapy is planned, selective serotonin reuptake inhibitors (SSRIs) are first-line treatment, with few exceptions

Recognition and Assessment of Common Mental Disorders in Young People/Rangatahi/Tamariki

Recognition of Common Mental Disorders in Young People

Young people/rangatahi/tamariki are defined in this context as individuals up to the age of 18 years and comprise both rangatahi (adolescents) and tamariki (young children). However, 18 years is a pragmatic cut off point that reflects the cut off age used in most research: it does not necessarily represent a developmental threshold.

C - A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services

C - Every interaction with a young person in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing. Both strengths and difficulties should be taken into account

C - Psychosocial wellbeing in adolescents should routinely be assessed using a standardised format, such as the HEEADSSS acronym (Home, Education/ Employment, Eating, Activities, Drugs, Sexuality, Suicide, Safety) (see Table 1 below)

C - Adolescents presenting in primary care should routinely be offered individual time with a practitioner

C - Brief tools may be used as optional aids to the practitioner's clinical assessment. Valid brief tools include:

- The Strengths and Difficulties Questionnaire (SDQ)
- The Short Moods and Feelings Questionnaire (SMFQ)
- Reynolds Adolescent Depression Scale (RADS)
- The Substance Use and Choices Scale (SACS)
- The CRAFFT acronym (A tool designed specifically for adolescents for detecting alcohol and substance abuse, and dependence.)

See "Appendix D: Assessment Tools for Common Mental Disorders" in the original guideline document for links to these tools.

GPP - Practitioners involved in the assessment of young people for mental disorders should endeavour to build a supportive and collaborative relationship with the young person and their family/whānau

Whānau is a much wider concept than the nuclear family. It approximates what non-Māori would generally understand to be an extended family. For Māori, whānau provides care, nurturing, identity and a sense of belonging and purpose. The goal of health for Māori is whānau ora: 'Māori families supported to achieve their maximum health and wellbeing'.

GPP - Practitioners should discuss the right to confidentiality and exceptions to confidentiality with the young person

GPP - In young children, a standardised format such as the HEARTS acronym (Home, Education, Activities, Relationships, Temper, Size) should be used for routine assessment of psychosocial wellbeing (see Box 3.3 of the original guideline document)

GPP - Practitioners should be aware of the cultural identity and health care preferences of young people in their care

Table 1: HEEADSSS
The HEADSS acronym updated in 2004 to HEEADSSS or HE^2ADS^3 is a well-known prompt to structure a psychosocial assessment in adolescents. It has the advantage of progressing from routine questions to more probing ones, giving the practitioner a chance to establish rapport before approaching the most difficult areas. However, the order of the interview depends on the dictates of common sense and clinical instinct and the young person's presenting complaint should be addressed as a priority. **H**ome: relationships, communication, anyone new? **E**ducation/Employment: ask for actual marks, hours, responsibilities **E**ating: body image, weight changes, dieting, exercise **A**ctivities: with peers, with family **D**rugs: tobacco, alcohol, other drugs – use by friends, family, self **S**exuality: sexual identity, relationships, coercion, contraception, pregnancy, sexually transmitted infections (STIs) **S**uicide and depression: sadness, boredom, sleep patterns, anhedonia **S**afety: injury, seatbelt use, violence, rape, bullying, weapons Issues of ethnic identity may also be critical domains, particularly among adolescents/rangatahi from minority cultures.*
*The earlier version, HEADSS, has been adapted for New Zealand.

Asking about Sexual Identity

In order to give a young person the opportunity to acknowledge their sexual identity, the practitioner could say:

- How do you feel about relationships in general/about your own sexuality?
- Some people are getting involved in sexual relationships. Have you had a sexual experience with a guy or girl or both?

Ask for permission to pass relevant information to other health professionals involved in the young person's care. This may save them the stress of having to explain themselves anew.

Determining Severity in Young People and When to Refer

C - A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services

C - A young person with severe depression should be referred urgently to secondary care mental health services

GPP - A young person with suspected bipolar disorder should be referred urgently to secondary care mental health services

<u>Management of Depression in Young People/Rangatahi/Tamariki</u>

Management of Depression in Young People

C - A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services

C - A young person with severe depression should be referred urgently to secondary care mental health services

C - Practitioners involved in the management of a young person with depression, should endeavour to build a supportive and collaborative relationship with the young person and their family/whānau

C - A young person with mild or moderate depression should typically be managed within primary care services

C - Practitioners should consider involving support services such as school guidance counsellors or family services in the management of a young person with depression

C - If a young person with depression does not report substantial improvement after 6–8 weeks of treatment, he/she should be referred to secondary care mental health services

C - Antidepressant treatment of a young person (<18 years) should not be initiated in primary care without consultation with a child and adolescent psychiatrist

GPP - When planning management of a young person with depression, practitioners should consider symptom severity, symptom persistence, functional impairment, response to any previous intervention and also the wider psychosocial context, identifying factors that may impact positively or negatively on outcome

GPP - Initial management in primary care of a young person with mild to moderate depression should include active listening, problem identification, advice about simple self-management strategies and systematic follow-up comprising 2-weekly monitoring (e.g., by phone/text/email)

GPP - A young person being treated for depression in primary care should be seen for reassessment at 2–4 weeks

GPP - A young person who reports improvement with treatment in primary care should be proactively monitored (by phone, email, text, or face-to-face) 1–2 monthly until he/she has a satisfactory response to treatment (remission of symptoms/return to normal function). He/she should have an action plan to use if symptoms recur (i.e., what to do and who to contact)

GPP - If the young person reports no improvement at 2–4 weeks, he/she should receive an extended appointment for intensified support. A simple psychological intervention such as structured problem-solving therapy should be offered

GPP - If the young person reports deterioration in symptoms at 2–4 weeks, either treatment should be intensified or he/she should be referred to secondary care mental health services, depending on the severity of symptoms

GPP - Counselling for young people in primary care should use a recognized therapeutic approach which targets depression and related problems and which focuses on resilience and behavioural support

GPP - If another health practitioner delivers psychotherapy to a young person with depression in primary care, there should be regular communication about the young person's progress

Recognition and Assessment of Common Mental Disorders in Adults/Pakeke

Recognition of Common Mental Disorders in Adults

C - An adult with serious suicidal intent, psychotic symptoms or severe and persistent self-neglect should be referred immediately to secondary care mental health services

C - Targeted screening for common mental disorders is indicated for adults not well-known to the practitioner and for:

- People with chronic illness, a history of mental disorder or suicide attempt, multiple symptoms or a recent significant loss
- Other high prevalence groups, such as Māori (especially Māori women) and older adults in residential care
- Women in the antenatal and postnatal period

B - Targeted screening for depression and anxiety should include the use of verbal 2–3 question screening tools (see Table 2 below)

GPP - Every interaction with an adult in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing. Both strengths and difficulties should be taken into account

GPP - The practitioner should strive to establish and maintain a good therapeutic relationship with the patient, as this increases the likelihood that mental disorders will be identified

GPP - Targeted screening for substance abuse should comprise a verbal 2–3 question screening tool

GPP - Targeted screening should be conducted annually

GPP - Brief tools are optional aids for use by the primary care practitioner as an adjunct to clinical assessment. Examples of brief tools include:

- The Kessler 10 (K10)
- The Patient Health Questionnaire for Depression (PHQ-9)
- The Generalised Anxiety Disorder Scale (GAD-7)
- The Alcohol Disorder Use Identification Test (AUDIT)
- The Case-finding and Help Assessment Tool (CHAT)

See "Appendix D: Assessment Tools for Common Mental Disorders" in the original guideline document for links to the above tools.

GPP - Practitioners should be aware of the cultural identity and health care preferences of people in their care

Table 2: Verbal 2-3 Questions Screening Tools for Common Disorders

Screening Questions for Depression

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by little interest or pleasure in doing things?

If Yes to either question, ask Help question (below)

Screening Question for Anxiety

During the past month have you been worrying a lot about everyday problems?

Table 2: Verbal 2-3 Questions Screening Tools for Common Disorders
If Yes, ask Help question (below) **Screening Questions for Alcohol and Drug Problems** • Have you used drugs or drunk more than you meant to in the last year? • Have you felt that you wanted to cut down on your drinking or drug use in the past year? If Yes to either question, ask Help question (below) **Help Question** Is this something with which you would like help? Options: no / yes, but not now / yes **Further Action** A positive response to one of the screening questions detects most cases of the relevant disorder. If a person responds positively to a screening question and identifies that they want help to address the issue, the GDT recommends that the practitioner proceeds with further clinical assessment, reschedules a further consultation or refers the person to their general practitioner/practice nurse team, as appropriate.

Determining Severity in Adults and When to Refer

Assessing Severity of Depression and When to Refer

C - An adult with serious suicidal intent, psychotic symptoms or severe and persistent self-neglect should be referred immediately to secondary care mental health services

B - Practitioners should consider the use of a tool such as the Patient Health Questionnaire for Depression (PHQ-9) for assessment of the severity of depression

GPP - An adult with suspected new-onset bipolar disorder should be referred urgently to secondary care mental health services

GPP - When assessing the severity of depression in an adult and planning management, practitioners should consider symptom severity, symptom persistence, functional impairment, response to any previous intervention and also the wider psychosocial context, identifying factors that may impact positively or negatively on outcome

Management of Depression in Adults/Pakeke

Management of Depression in Adults

C - An adult with serious suicidal intent, psychotic symptoms or severe and persistent self-neglect should be referred immediately to secondary care mental health services

C - First-line treatment for an adult with mild depression is active support, advice on exercise and self-management, and referral to psychosocial helping agencies as required (e.g., relationship counselling)

B - First-line treatment for an adult with moderate depression is either an SSRI or a psychological therapy (e.g., 6–8 sessions of problem-solving therapy or cognitive behavioural therapy [CBT] over 10–12 weeks)

B - For an adult presenting initially with severe depression, the practitioner should consider a combination of antidepressant medication with a structured psychological intervention (e.g., CBT or interpersonal psychotherapy [IPT], 16–20 sessions)

C - An adult starting antidepressant treatment who is considered at increased risk of suicide or is younger than 30 years should be followed up at 1 week and monitored 1–2 weekly, preferably face-to-face, until the risk is no longer considered significant, then at least 2 weekly until there is clear improvement

C - An adult starting antidepressant treatment who is not considered at increased risk of suicide should be reviewed by the health practitioner within 1–2 weeks and monitored at least 2 weekly until there is clear improvement

C - If an adult on antidepressant medication has had only a partial response after 3–4 weeks, consider increasing the dose

C - If an adult on antidepressant medication has not responded to treatment by 4–6 weeks, review the treatment plan and consider either increasing the dose, changing the antidepressant, or changing or adding a psychological therapy

B - An adult being treated for depression should be actively monitored and supported (e.g., by phone, text, email or face-to-face) by an appropriately trained member of the primary care team, informed by clear treatment protocols

B - Practitioners should consider the use of a tool such as the Patient Health Questionnaire for Depression (PHQ-9) to assist in the monitoring of treatment response in an adult with depression

C - If another health practitioner delivers psychotherapy to an adult with depression, the primary care team should be in regular communication about the individual's progress

C - An adult with depression who is treatment resistant should be referred urgently to secondary care mental health services while continuing treatment. Treatment resistance is defined as an unsatisfactory response after adequate trial of two antidepressants (with or without psychological therapy)

B - An adult with depression who is responding to antidepressant treatment should normally continue to take the antidepressant for at least 6 months after remission of an episode of depression in order to reduce the risk of relapse

GPP - When planning the management of an adult with depression, the practitioner should consider: symptom severity and symptom persistence; functional impairment; response to any previous intervention; and the individual's wider psychosocial context, identifying factors that may impact positively or negatively on outcomes

GPP - The practitioner should endeavour to build a supportive and collaborative relationship with an adult with depression and their family/whānau

GPP - A practitioner managing an adult with severe depression in primary care needs to have easy access to consultation with a psychiatrist

GPP - First-line treatment for an adult with melancholic depression is a tricyclic antidepressant

GPP - If an adult on antidepressant medication has had no or minimal response after 3–4 weeks, or if side effects are unacceptable, review the treatment plan and consider changing to a different antidepressant, or changing to or adding a psychological therapy

GPP - If an adult with mild depression does not respond to supportive treatment (psychosocial support and self-management strategies) within 2–4 weeks (i.e., ≥50% reduction in symptoms) the patient and practitioner should review the treatment plan and consider intensifying, changing or augmenting measures taken to date

GPP - The primary care team should include members skilled in conducting brief psychological interventions for depression

GPP - Psychological therapies offered should use a recognised therapeutic approach which targets depression and related problems and which focuses on resilience and behavioural support

Special Issues: Women with Mental Disorders in the Antenatal and Postnatal Period

Women in the Antenatal and Postnatal Period

C - As part of routine antenatal care, the practitioner should enquire whether a woman has any history of mental disorder or any family history of mental illness in the antenatal or postnatal period

C - At a pregnant woman's first contact with primary care, her 'booking' visit and 6-week postnatal check, the practitioner should consider the use of the verbal 2–3 question screening tool for depression as part of routine assessment (see Table 2 above)

C - A woman with depression in the antenatal or postnatal period requires full discussion of the risks and benefits of treatment options and the risks of untreated depression. The uncertain state of the evidence should be acknowledged

C - There should be close collaboration and sharing of information between the midwife, general practitioner and other practitioners involved in the care of a woman with antenatal or postnatal depression. All relevant information should be available to the Lead Maternity Carer

C - Nonpharmacological interventions such as enhanced social support and/or a psychological intervention should be considered before prescribing medication for antenatal or postnatal depression, especially for a woman with mild symptoms or in very early pregnancy

C - If a woman's response to a verbal 2–3 question screening tool arouses concern about a possible mental disorder (or if other issues do so) she should normally be referred promptly for further clinical assessment by her general practitioner/practice nurse team. This should include a check for suicidal ideation or intent

C - If a possible mental disorder or a history of significant mental disorder is identified in a woman in the antenatal or postnatal period, her general practitioner/practice nurse team should be made aware, even if no referral is made (e.g., referral is declined), provided the woman consents

C - A brief psychological intervention (e.g., 6–8 sessions of non-directive counselling, interpersonal psychotherapy [IPT] or cognitive behavioural therapy [CBT]) should be considered as a first-line intervention in the management of a woman with mild to moderate depression in the antenatal or postnatal period

C - For a woman with depression in the antenatal or postnatal period who does not respond to initial treatment, a structured psychological therapy (e.g., CBT or IPT) could be considered, in consultation with maternal mental health services

C - An antidepressant may be considered as first-line treatment for a woman with moderate to severe depression in the antenatal or postnatal period, after thorough discussion of the likely benefits and possible risks of treatment

C - A woman with severe depression in the antenatal or postnatal period should be managed in consultation with maternal mental health services or other appropriate psychiatric services

C - If a woman who is pregnant or planning pregnancy is being treated with an antidepressant, her treatment preference, previous history and risk should be reviewed. If appropriate, attempts should be made to withdraw the antidepressant and substitute an alternative treatment and/or ensure that the antidepressant with the lowest risk profile is used

GPP - At a pregnant woman's first contact with primary care, at her 'booking' visit and 6-week postnatal check, the practitioner should consider the use of verbal 2–

3 question screening tools for anxiety and substance abuse as part of routine assessment

GPP - A practitioner should regularly review his/her practice in relation to antidepressant prescribing during the antenatal or postnatal period and consider seeking specialist advice when initiating antidepressant treatment in a woman who is pregnant or breastfeeding

GPP - A practitioner should support breastfeeding in a woman with depression in the postnatal period who opts to take antidepressants, provided she is well-informed about known risks and benefits

GPP - A woman with depression in the postnatal period should be encouraged to attend a mother and baby support group

Advice for women It may be helpful to advise women that the 'postpartum blues' are a different entity from depression. The 'blues', with characteristic tearfulness, anxiety and low mood, are relatively common but are transient, peaking at 3–5 days after birth and resolving by 10–14 days.

Special Issues: Older Adults/Koroua/Kuia

Older Adults

C - Targeted screening for common mental disorders is indicated for older adults in groups with high prevalence rates including:

- Older adults in residential care
- Older adults with a history of mental disorder or suicide attempt
- Older adults with multiple symptoms
- Older adults with a recent significant loss

C - An older adult presenting with possible cognitive impairment should be assessed for both dementia and depression

C - Where there is a rapid change in cognitive status in an older adult, medical assessment should exclude delirium

C - An older adult with depression should be offered the same range of psychological therapies as other adults: chronological age should not be a bar to specific therapies

C - SSRIs are suitable as a firstline antidepressant for an older adult: for a patient also taking other medications, choose one with a low risk of drug interactions

C - An older adult prescribed antidepressants should be carefully monitored for adverse effects

C - Where antidepressants are the treatment of choice, treatment for an older adult with depression and dementia should be as for other older adults with depression

GPP - Among older adults living in residential care, older adults with other risk factors or where there is clinical concern, routine psychosocial assessment should include questions that screen for depression, anxiety and substance abuse. This assessment should be conducted annually

GPP - Brief tools are optional aids for use by the primary care practitioner as an adjunct to clinical assessment. Examples of brief tools for detecting depression among older adults include:

- The Geriatric Depression Scale (GDS)
- The Patient Health Questionnaire for Depression (PHQ-9)

GPP - Clinical assessment of an older adult for dementia and depression should include the use of tools to assess cognitive function, such as the Mini Mental State Examination (MMSE) and/or clock drawing test, in addition to a tool to assess for depression (such as the GDS or the PHQ-9)

GPP - Assessment of an older adult with depressive symptoms should include a physical examination, complete blood count and thyroid function tests. The practitioner should also consider checking creatinine and B12 and folate levels

GPP - An older adult with depression should be offered advice on simple behavioural measures to increase social, physical and/or intellectual activity

GPP - In an older adult starting treatment with a SSRI consider checking serum sodium after 1 week and after each dose adjustment, especially if the patient is at risk of hyponatraemia (e.g., frail, on diuretics, has renal impairment)

GPP - In a frail older adult prescribed antidepressants, treatment should be initiated at a low dose and increased slowly to optimisation or until a response is achieved

Definitions:

Grades of Recommendations

Grades indicate the strength of the supporting evidence rather than the importance of the evidence.

A - The recommendation is supported by good evidence (based on a number of studies that are valid, consistent, applicable and clinically relevant).

B - The recommendation is supported by fair evidence (based on studies that are valid, but there are some concerns about the volume, consistency, applicability and clinical relevance of the evidence that may cause some uncertainty but are not likely to be overturned by other evidence).

C - The recommendation is supported by international expert opinion.

Good Practice Points (GPP) - Where no evidence is available, best practice recommendations are made based on the experience of the Guideline Development Team, or feedback from consultation within New Zealand.

CLINICAL ALGORITHM(S)

The original guideline document contains clinical algorithms for:

- The management of depression in young people in primary care
- The management of depression in adults in primary care
- The management of severe depression in adults in primary care
- The management of moderate depression in adults in primary care
- The management of mild depression in adults in primary care

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate identification and management of common mental disorders and depression among young people and adults in the primary care setting.

POTENTIAL HARMS

Selective Serotonin Reuptake Inhibitors (SSRIs)

- SSRIs are overall fairly well tolerated, apart from mild nausea, occasional diarrhoea and sometimes headache. Gastrointestinal effects usually settle within 2 weeks.
- Sexual problems, such as decreased libido and difficulty achieving orgasm, occur in around 40% of people taking SSRIs, and in around 30% of cases the problem is likely to be drug-related, though estimates vary widely.
- Some people gain weight and there is also an increased risk of bleeding.
- Fluoxetine has a long half-life, which may cause problems with washout periods when switching to other antidepressant drugs, but has the advantage of causing less withdrawal symptoms.
- Increases in anxiety, restlessness or agitation may occur in the first few weeks of SSRI treatment. This may be very distressing and can be associated with increased suicidality.
- Patients should be warned that they may experience withdrawal symptoms, which are usually mild and self-limiting. Common withdrawal symptoms for

SSRIs are flu-like symptoms, 'shocklike' sensations, dizziness, excessive dreaming, insomnia and tearfulness.
- There is some evidence that SSRIs may increase the risk of premature labour. Women should be informed of a possible link between SSRIs in early pregnancy and the occurrence of birth defects. Late in pregnancy, concerns over neonatal toxicity or drug withdrawal associated with third trimester exposure to SSRIs (e.g., irritability, respiratory difficulties and feeding problems) may prompt some women to lower the dose of SSRIs until after delivery. (For more information see "Safety and Adverse Effects on the Infant/Foetus" in the original guideline document.)
- If a pregnant woman decides to keep taking antidepressants (including SSRIs), she should be advised that the pharmacokinetics of many drugs change during pregnancy, especially in the third trimester, due to increased fluid volumes.
- Older patients may be at increased risk of rare but potentially serious adverse events associated with SSRIs, such as hyponatraemia and weight loss. Moreover, a large observational study published recently reports a doubling of fracture risk in people aged 50 years and over taking SSRIs.

Tricyclic Antidepressants (TCAs)

- All TCAs cause anticholinergic side effects (such as dry mouth, blurred vision, constipation, urinary retention and sweating), sedation and postural hypotension. Usual recommendations are to start with a low dose and titrate up to the therapeutic serum level as quickly as the patient can tolerate this. TCAs can cause ventricular arrhythmias in the absence of adequate oxygenation of heart muscle (e.g., with ischaemic heart disease) and in overdose. Overdose can also cause seizures.
- Withdrawal of TCAs can cause flu-like symptoms and insomnia. If symptoms are severe, the patient may need to resume taking the antidepressant and reduce it more slowly.
- There have been few documented problems arising from the use of TCAs in pregnancy, though data are limited, but they are generally avoided nowadays due to their adverse effects and risk of fatal overdose.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Doxepin is contraindicated in lactation, due to case reports of drowsiness and hypotonia in the breastfed infants of mothers taking this drug.
- Antidepressant medication should not be continued in a confused older person unless there is clear clinical evidence of benefit.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Evidence-based best practice guidelines are produced to help health care practitioners and consumers make decisions about health care in specific clinical circumstances. Research has shown that if properly developed,

communicated and implemented, guidelines can improve care. The advice in this guideline is based on evidence from epidemiological studies and other research. Where no evidence is available, but guidance is needed, recommendations for best practice are developed through a systematic consensus process based on the experience of the Guideline Development Team.

- While guidelines represent a statement of best practice based on the latest available evidence (at the time of publishing), flexibility will be required in local interpretation and they are not intended to replace the health practitioner's judgment in each individual case.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The New Zealand Guidelines Group (NZGG) has identified four principles which should characterise implementation.

These are:

1. Strong visibility of the guideline, given the opportunity that evidence-based care represents to improve the lives of people living with depression
2. The use of multifaceted approaches to engage practitioners and patients
3. Recognition that all implementation is ultimately 'local'; this means an emphasis on providing useful tools and processes for practitioners, with central agencies as facilitators of change
4. A commitment to supporting the sector to measure its performance in following the guideline's recommendations

See chapter 10 of the original guideline document for a detailed discussion of potential implementation activities, such as improved access and uptake of patient self-management tools, quality improvement collaboratives, workforce development, electronic evidence resources, broad guideline dissemination, and evaluation and performance indicator development.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New Zealand Guidelines Group. Identification of common mental disorders and management of depression in primary care. Wellington (NZ): New Zealand Guidelines Group; 2008 Jul. 188 p. [580 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Jul

GUIDELINE DEVELOPER(S)

New Zealand Guidelines Group - Private Nonprofit Organization

SOURCE(S) OF FUNDING

New Zealand Guidelines Group

This guideline was funded by the Ministry of Health and its development was independently managed by the New Zealand Guidelines Group. Appraisal of the evidence, formulation and reporting of recommendations are independent of the Ministry of Health.

GUIDELINE COMMITTEE

Guideline Development Team

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Guideline Development Team Members: Professor Tony Dowell (*Chair*), General Practitioner, Island Bay, Wellington, Professor of Primary Health Care and General Practice, University of Otago, Wellington; Tim Antric (from August 2007), Project Manager – National Depression Campaign, Wellington, Mental Health Foundation of New Zealand, Auckland; Professor Bruce Arroll; Professor and Head of Department, Department of General Practice and Primary Health Care, University of Auckland, Auckland; Dr Clive Bensemann, Psychiatrist, Mental Health Services

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Professor Bruce Arroll is on the primary care committee of the Future Forum, funded by Astra Zeneca UK and has received financial support to attend the annual conference in Europe for the past four years. Bruce received financial support from the PHARMAC committee to run three CME (continuing medical education) sessions.

Dr Sunny Collings has received research funding from the Health Research Council and the Ministry of Health.

Dr John Cosgriff has received financial support from Jannsen-Cilag for the Metabolic Symposium Atypical Antipsychotics.

Professor Pete Ellis has received financial support from Eli Lilly for funding a PhD student for investigator initiated research, ending June 2006. Pete Ellis has a beneficial interest with shares in CSL Limited, GlaxoSmithKline, Pfizer and Roche.

Dr Allen Fraser has received financial support from Sanofi Synthelabo to attend the annual bipolar disorder meeting, 2001–2006, and the International Society for Bipolar Disorders Pittsburgh 2003.

Dr Mark Huthwaite has received financial support from Eli Lilly, Lundbeck, Jansen Cilag, Astra-Zeneca and Pfizer to conduct clinical drug trials and to attend and present at conferences and meetings.

ENDORSER(S)

College of Nurses Aotearoa NZ - Academic Institution
Mental Health Foundation of New Zealand - Medical Specialty Society
New Zealand Association of Counsellors - Professional Association
New Zealand College of Clinical Psychologists - Professional Association
New Zealand College of Mental Health Nurses, Inc. - Professional Association
Paediatric Society of New Zealand - Medical Specialty Society
Royal Australian and New Zealand College of Psychiatrists - Professional Association
Royal New Zealand College of General Practitioners - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

Print copies: Available from the New Zealand Guidelines Group Inc., Level 10, 40 Mercer Street, PO Box 10 665, The Terrace, Wellington, New Zealand; Tel: 64 4 471 4180; Fax: 64 4 471 4185; e-mail: info@nzgg.org.nz.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Identification of common mental disorders and management of depression in primary care: guideline summary. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2008 Jul. 12 p.

Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

Additionally, an assessment of suicide risk tool can be found in Appendix C in the original guideline document.

PATIENT RESOURCES

The following is available:

- New Zealand Guidelines Group (NZGG). Depression. There is a way through it. Information for you, and your family, whanau, friends, and support networks. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2006. 16

p. Electronic copies: Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on December 10, 2008. The information was verified by the guideline developer on January 4, 2009.

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